



## MEDICAL FORM

Camper's Name \_\_\_\_\_ Age \_\_\_\_\_

Parent (Guardian) \_\_\_\_\_ Phone \_\_\_\_\_

Emergency Phone (office, relative, neighbor) \_\_\_\_\_

PLEASE NOTE: Health laws require that the information requested below be completed and signed by a physician. Please return on or before the first day your child attends camp.

### RECORD OF IMMUNIZATIONS

- |                             |       |       |       |       |       |
|-----------------------------|-------|-------|-------|-------|-------|
| 1. DPT                      | _____ | _____ | _____ | _____ | _____ |
| 2. POLIO                    | _____ | _____ | _____ | _____ | _____ |
| 3. MEASLES (Rubella)        | _____ | _____ | _____ | _____ | _____ |
| 4. MUMPS                    | _____ | _____ | _____ | _____ | _____ |
| 5. RUBELLA (German Measles) | _____ | _____ | _____ | _____ | _____ |
| 6. HIB                      | _____ | _____ | _____ | _____ | _____ |
| 7. HEPATITIS                | _____ | _____ | _____ | _____ | _____ |

Allergies: (Please use Allergy Action Form on website for more detailed explanation of allergy)

\_\_\_\_\_

Chronic diseases or disabilities:

\_\_\_\_\_

\_\_\_\_\_

Special medical attention needed:

\_\_\_\_\_

\_\_\_\_\_

Can this camper participate in all camp activities? YES \_\_\_\_\_ NO \_\_\_\_\_  
(If "NO" please explain on the back of this form)

Camper can have his/her own sunscreen and/or bug spray applied at camp? YES \_\_\_\_\_ NO \_\_\_\_\_  
(If "NO" please explain on the back of this form)

Name of Physician \_\_\_\_\_

Address of Physician \_\_\_\_\_

Phone of Physician \_\_\_\_\_

Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_